MEDICARE Has Improved

Catastrophic Protection and Other New Benefits

An Official Notice To Medicare Beneficiaries Explaining Benefits Under The Medicare Catastrophic Coverage Act of 1988

"Let us remove a financial specter facing our older Americans— the fear of an illness so expensive that it can result in having to make an intolerable choice between bankruptcy and death."

President Ronald Reagan
1986 State of the Union Message

DEAR MEDICARE BENEFICIARY:

Beginning January 1, 1989, Medicare will be expanded to cover catastrophic health care costs.

This new plan meets President Reagan's call to protect the elderly and disabled against financial ruin in the event of a prolonged hospital stay or other high medical costs.

We are proud to provide this new coverage as part of our continuing commitment to affordable quality health care.

OTIS R. BOWEN, M.D.
Secretary
U.S. Department of Health and Human Services

MEDICARE EXPANDED TO INCLUDE CATASTROPHIC HEALTH INSURANCE

Medicare has been changed to better protect its 32 million elderly and disabled beneficiaries from ''catastrophic'' hospital, doctor and prescription drug bills. The changes, mandated by the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360), will be introduced beginning January 1, 1989.

The new law limits the amount you as a Medicare beneficiary must pay for hospital care, physician services, medical supplies, and outpatient drugs covered by Medicare. It increases home-health, skilled nursing facility, and hospice coverage, and adds breast-cancer screening and respite care benefits.

These new and improved benefits will be made available to you automatically if you are a Medicare beneficiary or when you become eligible for the program. You are not required to do anything to receive this coverage. If you are enrolled in Part A only and want to enroll in Part B so as to take advantage of all of the benefits, you will be given a chance to do so during the general enrollment period from January 1 through March 31 each year.

NEW HOSPITAL BENEFITS:

Medicare hospital insurance (Part A) helps pay for medically necessary care in a Medicare-approved hospital, skilled nursing facility and hospice. It also pays for certain home health care.

Beginning January 1, 1989, you will be entitled to unlimited hospitalization for approved care after you pay a single annual deductible, estimated at $564 in 1989. (A deductible is an amount you must spend before Medicare begins paying for services and supplies covered by the program.) Medicare will pay for your hospital care only if you meet the following four conditions: (1) a doctor prescribes inpatient hospital care for treatment of your illness or injury, (2) you require the kind of care that can only be provided in a hospital, (3) the hospital is participating in Medicare, and (4) the Utilization Review Committee of the hospital or a Peer Review Organization does not disapprove your stay.

Once you meet these conditions and pay the single annual deductible, Medicare pays 100 percent of the approved charges for your care. This is regardless of the costs, length of stay or number of times you are admitted to the hospital in any one year. And if you pay the deductible during December, you do not have to pay it again if you are still a patient in or are readmitted to the hospital in January of the following year.

While most hospital-related costs are covered by Medicare, you must pay for certain services and conveniences, such as a private room (unless it is a medical necessity), private duty nurses, a television, radio, or telephone in the room.

PSYCHIATRIC HOSPITAL BENEFIT:

The 190-day lifetime limit on inpatient psychiatric hospital services remains unchanged.

SKILLED NURSING FACILITY CARE:

The new law provides for 150 days of care per calendar year in a Medicare-certified skilled nursing facility *starting January 1, 1989.* If you are admitted to a skilled nursing facility, you will be responsible for copayments (a share of the costs) for the first eight days of care each year. The copayment is estimated at $22 per day in 1989. Medicare pays all other allowable charges for up to 150 days of covered care even if you are discharged and readmitted to a skilled nursing facility more than once during a calendar year. The requirement that you be hospitalized at least three days immediately before entering a skilled nursing facility to qualify for Medicare coverage will be eliminated for stays starting on or after January 1, 1989.

Skilled nursing facility care is not the same as custodial nursing home care. Skilled nursing facility care is acute care while custodial nursing home care is long-term care. A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide skilled nursing care or rehabilitation and other related health services. Most nursing homes in the United States are not skilled nursing facilities and many skilled nursing facilities are not certified by Medicare. While Medicare does not cover custodial care in a nursing home, some insurance companies offer policies that do.

- **HOME HEALTH CARE:** *Effective January 1, 1990*, if you qualify for home health care, reasonable and necessary skilled nursing care and/or home health aide care will be available to you for up to six days a week for as long as it is prescribed by a doctor. If you need such home health care seven days a week, you will be entitled to 38 consecutive days of care. The 38-day limit can be extended for a period of time under special circumstances.

- **HOSPICE CARE:** Beginning in 1989, unlimited hospice care will be available to beneficiaries who are recertified as terminally ill after 210 days of care in a hospice.

DOCTOR AND OTHER OUTPATIENT SERVICES (Part B): Medicare Part B helps pay for medically necessary doctor services, outpatient hospital services, home health care, and various medical services and supplies not covered by the hospital insurance part of Medicare. It is voluntary, and enrollees pay a monthly premium.

Effective January 1, 1990, your share of approved charges for services and supplies covered by Part B will be limited to $1,370 a year. You will be required to pay the first $75 (deductible) of charges approved by Medicare and 20 percent of all approved charges after that until these out-of-pocket expenses total $1,370. It does not matter whether these expenses are paid directly by you or by your private insurance company. Once the $1,370 amount is reached, Medicare will pay 100 percent of all other approved charges under Part B for the remainder of the calendar year. (An approved charge is an amount Medicare has determined to be a reasonable price for physicians and other covered medical services.)

If a doctor or medical supplier charges more than Medicare's approved charge, you must pay the difference and it will not count toward the $1,370 limit. You will continue to be responsible for any charges over what Medicare allows even after you reach the $1,370 out-of-pocket limit. Some doctors and suppliers agree to not charge more than the Medicare-approved amount for services and supplies. They are called participating physicians and suppliers and their names and addresses may be obtained from the Medicare carrier for your area.

RESPITE CARE BENEFIT: This new benefit, *effective January 1, 1990,* pays for the temporary services of a home health aide to provide relief for an individual who normally helps a Medicare beneficiary who requires assistance with essential daily personal care. Medicare will pay for up to 80 hours per year of home health aide and personal care services. You can use this benefit only if you are chronically dependent and have met either the annual deductible for outpatient prescription drugs or the $1,370 Part B catastrophic limit for the year.

MAMMOGRAPHY: This new benefit, which goes into *effect January 1, 1990,* will pay up to $50 for X-ray screening for the detection of breast-cancer. Women 65 or older can use the benefit for a mammogram every other year, while certain younger disabled women covered by Medicare can use it for more frequent examinations.

NEW PRESCRIPTION DRUG BENEFIT: Medicare already pays for prescription drugs when you are in the hospital. *Beginning January 1, 1990,* the benefit will be expanded to cover a few outpatient prescription drugs in certain circumstances, and *in 1991 it will cover most prescription drugs as well as insulin.*

In 1990, Medicare will help pay for certain antibiotics and other drugs that are injected into the veins (intravenous) and can be safely used at home. Coverage also will be expanded in 1990 to include immunosuppressive drugs used in the second year and thereafter following a Medicare-covered organ transplant. Medicare already helps pay for immunosuppressive drugs taken the first year following a Medicare-covered organ transplant.

In 1990, you will have to pay the first $550 for these covered drugs. Medicare will then pay 80 percent of the cost of approved intravenous drugs and 50 percent of the cost of immunosuppressives used after the first year following a transplant. You will not have to pay the $550 deductible if your intravenous drug therapy began during a hospital stay and is continued at home, or for immunosuppressive drugs used in the first year after a transplant.

Effective January 1, 1991, Medicare will cover most other prescription drugs as well as insulin. You will be responsible for an annual deductible and copayments. In 1991 the deductible will be $600 and the copayment 50 percent. This means that after you pay the first $600 for covered outpatient prescription drugs,

Medicare will pay half of all other allowed drug charges for the remainder of the calendar year. In 1992 the deductible is estimated to be $652 and the copayment 40 percent. In 1993 and thereafter, if the new catastrophic coverage premiums have been sufficient to cover costs, Medicare will pay 80 percent of all the allowable drug charges in excess of the deductible. The deductible for 1993 is to be set at a later date.

PAYING FOR CATASTROPHIC HEALTH INSURANCE: Two new premiums are being added to pay for the catastrophic coverage. One will be an addition to the basic monthly Part B premium and the other will be a new annual income-tax-related premium. The extra charge to be added to the basic Part B premium will be $4 per month in 1989 and will gradually increase to $10.20 per month in 1993. It will be in addition to any increases in the monthly basic Part B premium which is $24.80 in 1988.

If you are a Social Security or Railroad Retirement beneficiary, any increase to you in the Part B premium cannot be greater than the cost-of-living adjustment in your monthly benefit for the year. In other words, if at sometime in the future the Part B premium were increased $6 per month and your cost-of-living adjustment for the year amounted to $5 a month, the increase in your monthly premium would be limited to $5.

While enrollment in Part B is still optional, you cannot buy Part B without also buying the new catastrophic benefits it provides. Everyone enrolled in Part B will be required to pay the new premium to be added to the basic Part B premium. Part B premium payments will not count toward the $1,370 out-of-pocket expense limit.

SUPPLEMENTAL PREMIUM: Besides the change in the basic premium, a supplemental premium based on your income tax liability is to be paid on Federal tax returns for 1989.

You must pay the supplemental premium if you are entitled to or eligible for Medicare Part A for more than six full months in the taxable year and your Federal income tax liability for the year is $150 or more.The only exceptions are for certain Medicare-eligible individuals living in a foreign country and those who pay a monthly premium for Part A coverage. You do not have to pay the premium if your tax liability for the taxable year is less than $150.

The supplemental premium rate is $22.50 for each $150 of Federal income tax liability for the 1989 tax year. This means that if you pay $150 in Federal income taxes for 1989, your supplemental premium will be $22.50. If your tax is $300, the premium will be $45. The premium rate for each $150 of tax liability will rise to $37.50 in 1990, $39 in 1991, $40.50 in 1992, and $42 in 1993. There is, however, a limit on the amount you must pay each year. For 1989, the maximum supplemental premium is $800. It will increase to $850 in 1990, $900 in 1991, $950 in 1992, and $1,050 in 1993.

The maximum is double for a married couple as long as both were eligible for Part A for more than six full months during the taxable year.

Thus, a couple will pay a supplemental premium in 1989 at the rate of $22.50 for each $150 up to a maximum of $1,600. In the case of a joint return where only one spouse is eligible for Medicare, only one half of any tax liability is taken into account, and the $800 maximum applies. There are also special rules for governmental retirees to adjust for the fact that their government pensions are fully taxed while the pensions received by Social Security are not.

The supplemental premium will be administered through the Federal income tax system, with premium amounts computed from a table included with income tax forms and collected along with income tax payments. You will be receiving information from the Internal Revenue Service in your 1988 tax package. If you have a tax-related question about the supplemental premium, you should call or visit your local Internal Revenue Service office.

The supplemental premium does not count toward the $1,370 out-of-pocket expense limit for Part B benefits.

- **PREPAYMENT PLANS:** If you are enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP), the new catastrophic coverage will be provided by your HMO or CMP. Additional information about this coverage and how it is to be provided by the plans will be mailed to you in the near future by the Health Care Financing Administration. If you are a federal retiree enrolled in the Federal Employees Health Benefits Program, special provisions of the new law may apply to you. The Office of

Personnel Management will contact you directly regarding these provisions. If you are not contacted by mid-September, you should write to the Office of Personnel Management, P.O. Box 275, Washington, D.C. 20044-0275.

MEDIGAP POLICIES: The new law requires companies that issue insurance to supplement Medicare (Medigap policies) to send a letter to their policyholders who are entitled to Medicare explaining the changes in the Medicare law and how it affects their policies' benefits and premiums. The letter is to be mailed by January 31, 1989, to Medigap policyholders of record as of January 1, 1989. Medigap policies must be revised to avoid duplicating the new Medicare catastrophic benefits. Contact your State insurance commissioner or insurance agent for additional information about Medigap policies.

WHERE CAN I GET MORE INFORMATION? If you require additional information about Medicare, contact the Medicare carrier that processes claims for your area. The carrier's telephone number is listed in *The Medicare Handbook*. Information, including the carrier's telephone number, also may be obtained by calling **1-800-888-1998.**

Questions about the supplemental premium should be directed to the Internal Revenue Service.

Department of
Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

Official Business
Penalty for Private use, $300

BULK RATE MAIL
POSTAGE &
FEES PAID
HHS
PERMIT NO. G28

**THIRD CLASS
BULK RATE**